CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I,	, aut	horize
	(Name of Patient)	(Name of alcohol/drug program making disclosure)
to:disclo	ose to,request from, orexchange w	ith:
	(Name of person and/or org	anization to which disclosure is to be made)
the followir	ng information:	
	(Nature and amount of information	to be disclosed, as specific and limited as possible)
The purpose	e of this disclosure is to:	
	(Purpose of dis	closure, as specific as possible)
Drug Abuse provided fo	e Patient Records, 42 C.F.R. Part 2, and r in the regulations. I also understand the	e Federal Regulations governing Confidentiality of Alcohol and cannot be disclosed without my written consent unless otherwise at I may revoke this consent at any time except to the extent that my event this consent will terminate automatically as follows:
	(Specific date, event, or	condition upon which consent expires)
Date	Signature of Patient	Printed Name of Patient
Date	Signature of Parent, Guardian or Authorized Representative, when required	Printed Name of Parent, Guardian or Authorized Representative, when required
Date 2/4/04-is	Signature of Witness	Printed Name of Witness